Health Financial Systems | PERRY COUNTY HOSPITAL | In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Falure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151322	Period: From 01/01/2012 To 12/31/2012	Worksheet S Parts I-III Date/Time Prepared: 5/30/2013 9:40 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/30/2013 Time: 9:40 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PERRY COUNTY HOSPITAL (151322) for the cost reporting period beginning 01/01/2012 and ending 12/31/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Encryption Information

ECR: Date: 5/30/2013 Time: 9:40 am
VYOJ1QjSaxZ171rut.8zr.NUvsgns0
psgkg09gPr.8TddzjBAjOQAfdFv0Nr
Y0Ef0URXKs0z9zIP

PI: Date: 5/30/2013 Time: 9:40 am
wGXyILPTPR9xE7BMODPf:rE1xaxcH0
R9yEH06C8ZZ9bnQFNgRDAKyghUaTdl
KZU40Cu6UM0odIrU

(Signed) _____
Officer or Administrator of Provider(s)

CFO
Title

5/30/13
Date

		Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	484,856	58,845	8,722	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	118,415	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	-556		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	603,271	58,289	8,722	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2013 9:13 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: ONE HOSPITAL ROAD	PO Box: X			1.00
2.00	City: TELL CITY	State: IN	Zip Code: 47856-	County: PERRY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	PERRY COUNTY HOSPITAL	151322	15999	1	07/01/2004	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PERRY COUNTY HOSPITAL SWING	15Z322	15999		07/01/2004	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	PERRY COUNTY HOSPITAL HHA	157177	15999		06/13/1986	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2012	12/31/2012	20.00
21.00	Type of Control (see instructions)	9		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	0	0	0	0	0	25.00

		Urban/Rural S 1.00	Date of Geogr 2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 9:13 am

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.			39.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME Average	Direct GME Average	
		1.00	2.00	3.00	
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00	61.00
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00			62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00			62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings				
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N			63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2013 9:13 am

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			0	76.00

			1.00		
	Long Term Care Hospital PPS				
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
	TEFRA Providers				
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.00

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I Date/Time Prepared: 5/30/2013 9:13 am

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
	Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
	All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		140.00

1.00	2.00	3.00

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part I | Date/Time Prepared: 5/30/2013 9:13 am

	Multicampus	1.00	
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5						0.00	166.00

	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act	1.00	
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	908,819	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-2 Part II | Date/Time Prepared: 5/30/2013 9:13 am

General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

Provider Organization and Operation

		Y/N 1.00	Date 2.00		
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00

		Y/N 1.00	Date 2.00	V/I 3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

Financial Data and Reports

		Y/N 1.00	Type 2.00	Date 3.00	
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	05/01/2013	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

Approved Educational Activities

		Y/N 1.00	Legal Oper. 2.00	
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

Bad Debts

		Y/N 1.00	
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00

Bed Complement

15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

PS&R Data

		Description 0	Part A Y/N 1.00	Part A Date 2.00	Part B Y/N 3.00	
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	04/02/2013	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions	N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.	N	33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N	35.00

		Y/N 1.00	Date 2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RICH	FERRIELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923832	RFERRIELL@ALLIANTMANAGEMENT.COM	43.00

		Part B Date 4.00		
	PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	04/02/2013		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2013 9:13 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	21	7,686	89,424.00	0	1.00
2.00	HMO						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,686	89,424.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,464	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9,150	89,424.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	2,459	382	3,726			1.00
2.00	HMO	122	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	631	0	631			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		31	31			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	3,090	413	4,388			7.00
8.00	INTENSIVE CARE UNIT	168	11	248			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		97	164			13.00
14.00	Total (see instructions)	3,258	521	4,800	0.00	246.74	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,393	0	5,947	0.00	6.64	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part I | Date/Time Prepared: 5/30/2013 9:13 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
27.00	Total (sum of lines 14-26)				0.00	253.38	27.00
28.00	Observation Bed Days		0	448			28.00
29.00	Ambulance Trips	948					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
33.00	LTCH non-covered days	0					33.00

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	714	143	1,209	1.00
2.00	HMO			28			2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	714	143	1,209	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-3 Part IV | Date/Time Prepared: 5/30/2013 9:13 am

		Amount Reported 1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	472,622	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,030,533	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	27,668	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	33,828	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	132,986	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	834,366	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	12,209	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,544,212	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-4
Component CCN: 157177 | Date/Time Prepared: 5/30/2013 9:13 am

Home Health Agency I | PPS

						1.00	
0.00	County				PERRY		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	123.00	0.00	102.00	225.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			15999			20.00
		Full Episodes Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,211	0	53	5	1,269	21.00
22.00	Skilled Nursing Visit Charges	429,000	0	18,795	1,775	449,570	22.00
23.00	Physical Therapy Visits	1,098	0	7	3	1,108	23.00
24.00	Physical Therapy Visit Charges	282,915	0	1,806	1,032	285,753	24.00
25.00	Occupational Therapy Visits	578	0	1	2	581	25.00
26.00	Occupational Therapy Visit Charges	129,993	0	225	450	130,668	26.00
27.00	Speech Pathology Visits	48	0	0	0	48	27.00
28.00	Speech Pathology Visit Charges	12,384	0	0	0	12,384	28.00
29.00	Medical Social Service Visits	21	0	2	0	23	29.00
30.00	Medical Social Service Visit Charges	6,174	0	588	0	6,762	30.00
31.00	Home Health Aide Visits	364	0	0	0	364	31.00
32.00	Home Health Aide Visit Charges	67,804	0	0	0	67,804	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,320	0	63	10	3,393	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	928,270	0	21,414	3,257	952,941	35.00
36.00	Total Number of Episodes (standard/non outlier)	153		24	1	178	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	39,491	0	2,698	685	42,874	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet S-10 | Date/Time Prepared: 5/30/2013 9:13 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.369412	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,987,593	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	10,069,340	6.00
7.00	Medicaid cost (line 1 times line 6)	3,719,735	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,732,142	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,732,142	19.00

		Uninsured patients 1.00	Insured patients 2.00	Total (col. 1 + col. 2) 3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	2,143,877	0	2,143,877	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	791,974	0	791,974	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	791,974	0	791,974	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	5,312,005	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	442,917	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)	4,869,088	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)	1,798,700	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)	2,590,674	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,322,816	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A | Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,062,349	1,062,349	283,322	1,345,671	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	94,691	94,691	2.00
4.00	00400	EMPLOYEE BENEFITS	126,528	4,291,342	4,417,870	-4,381,374	36,496	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,810,118	3,690,278	5,500,396	684,599	6,184,995	5.00
7.00	00700	OPERATION OF PLANT	294,921	937,044	1,231,965	246,249	1,478,214	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	908	94,592	95,500	4	95,504	8.00
9.00	00900	HOUSEKEEPING	207,245	52,207	259,452	166,093	425,545	9.00
10.00	01000	DIETARY	253,411	193,994	447,405	52,165	499,570	10.00
11.00	01100	CAFETERIA	0	0	0	140,206	140,206	11.00
13.00	01300	NURSING ADMINISTRATION	553,748	9,538	563,286	112,900	676,186	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	176,080	186,716	362,796	86,313	449,109	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,555,228	442,334	1,997,562	569,856	2,567,418	30.00
31.00	03100	INTENSIVE CARE UNIT	271,198	12,588	283,786	30,322	314,108	31.00
43.00	04300	NURSERY	27,658	0	27,658	29	27,687	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	448,693	549,930	998,623	116,619	1,115,242	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,307	0	27,307	28	27,335	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	861,744	973,992	1,835,736	331,841	2,167,577	54.00
60.00	06000	LABORATORY	627,194	751,210	1,378,404	124,065	1,502,469	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,005	152,507	162,512	12	162,524	62.00
65.00	06500	RESPIRATORY THERAPY	476,819	278,005	754,824	347,078	1,101,902	65.00
66.00	06600	PHYSICAL THERAPY	21,380	395,402	416,782	3,102	419,884	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	116,115	116,115	-23	116,092	67.00
68.00	06800	SPEECH PATHOLOGY	0	148,151	148,151	0	148,151	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,916	421,924	467,840	17,227	485,067	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	59,768	59,768	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,659	2,289,979	2,372,638	21,599	2,394,237	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	205,846	51,856	257,702	65,100	322,802	90.00
91.00	09100	EMERGENCY	814,578	1,593,129	2,407,707	227,487	2,635,194	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	511,259	358,594	869,853	138,261	1,008,114	95.00
101.00	10100	HOME HEALTH AGENCY	293,494	329,611	623,105	157,747	780,852	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		77,568	77,568	-77,568	0	113.00
116.00	11600	HOSPICE	0	8	8	0	8	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,703,937	19,460,963	29,164,900	-382,282	28,782,618	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,509,621	1,797,228	4,306,849	406,933	4,713,782	192.00
192.01	19201	MARKETING	35,118	228,119	263,237	-24,651	238,586	192.01
200.00		TOTAL (SUM OF LINES 118-199)	12,248,676	21,486,310	33,734,986	0	33,734,986	200.00

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-155,533	1,190,138	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-1,439	93,252	2.00
4.00	00400	EMPLOYEE BENEFITS	0	36,496	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-129,505	6,055,490	5.00
7.00	00700	OPERATION OF PLANT	-22,764	1,455,450	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	95,504	8.00
9.00	00900	HOUSEKEEPING	0	425,545	9.00
10.00	01000	DIETARY	-41	499,529	10.00
11.00	01100	CAFETERIA	-50,188	90,018	11.00
13.00	01300	NURSING ADMINISTRATION	0	676,186	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,748	445,361	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0	2,567,418	30.00
31.00	03100	INTENSIVE CARE UNIT	0	314,108	31.00
43.00	04300	NURSERY	0	27,687	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	-282,480	832,762	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	27,335	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-99,341	2,068,236	54.00
60.00	06000	LABORATORY	0	1,502,469	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	162,524	62.00
65.00	06500	RESPIRATORY THERAPY	-191,264	910,638	65.00
66.00	06600	PHYSICAL THERAPY	0	419,884	66.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A | Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
67.00	06700	OCCUPATIONAL THERAPY	0	116,092	67.00
68.00	06800	SPEECH PATHOLOGY	0	148,151	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-86,229	398,838	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	59,768	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,568	2,392,669	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	322,802	90.00
91.00	09100	EMERGENCY	-1,217,175	1,418,019	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	-4,074	1,004,040	95.00
101.00	10100	HOME HEALTH AGENCY	-2,574	778,278	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	-8	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,247,931	26,534,687	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,713,782	192.00
192.01	19201	MARKETING	0	238,586	192.01
200.00		TOTAL (SUM OF LINES 118-199)	-2,247,931	31,487,055	200.00

	Cost Center	Increases Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETRIA COST				
1.00	CAFETERIA	11.00	79,517	60,872	1.00
	TOTALS		79,517	60,872	
	B - INTEREST EXPENSE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	85,611	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	85,611	
	C - LEASE EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	131,883	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
	TOTALS		0	131,883	
	D - INSURANCE EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	15,123	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	14,471	2.00
	TOTALS		0	29,594	
	F - GAIN/LOSS FIXED ASSETS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,391	1.00
	TOTALS		0	5,391	
	G - DRUGS CHARGED				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	70,477	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	70,477	
	J - BILLABLE SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	66,910	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	10,046	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
	TOTALS		0	76,956	
	K - PLANT COST				
1.00	OPERATION OF PLANT	7.00	0	84,442	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	84,442	
	M - YELLOW PAGES				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	32,263	1.00
	TOTALS		0	32,263	
	P - IMPLANTABLE DEVICE				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	49,722	1.00
	TOTALS		0	49,722	
	R - PAYROLL				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	666,893	1.00
2.00	OPERATION OF PLANT	7.00	0	162,360	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	4	3.00
4.00	HOUSEKEEPING	9.00	0	166,093	4.00
5.00	DIETARY	10.00	0	192,554	5.00
6.00	CAFETERIA	11.00	0	352	6.00
7.00	NURSING ADMINISTRATION	13.00	0	112,900	7.00

RECLASSIFICATIONS

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		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	110,932	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	591,288	9.00
10.00	INTENSIVE CARE UNIT	31.00	0	30,564	10.00
11.00	NURSERY	43.00	0	29	11.00
12.00	OPERATING ROOM	50.00	0	170,560	12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	28	13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	333,165	14.00
15.00	LABORATORY	60.00	0	124,065	15.00
16.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	0	12	16.00
17.00	RESPIRATORY THERAPY	65.00	0	364,731	17.00
18.00	PHYSICAL THERAPY	66.00	0	3,754	18.00
19.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	39	19.00
20.00	DRUGS CHARGED TO PATIENTS	73.00	0	14,763	20.00
21.00	CLINIC	90.00	0	65,253	21.00
22.00	EMERGENCY	91.00	0	242,559	22.00
23.00	AMBULANCE SERVICES	95.00	0	158,005	23.00
24.00	HOME HEALTH AGENCY	101.00	0	164,570	24.00
25.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	698,289	25.00
26.00	MARKETING	192.01	0	7,612	26.00
	TOTALS		0	4,381,374	
	S - DEPRECIATION				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	136,316	1.00
	TOTALS		0	136,316	
500.00	Grand Total: Increases		79,517	5,144,901	500.00

RECLASSIFICATIONS

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		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - CAFETRIA COST					
1.00	DIETARY	10.00	79,517	60,872	0	1.00
	TOTALS		79,517	60,872		
	B - INTEREST EXPENSE					
1.00	INTEREST EXPENSE	113.00	0	77,568	10	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	8,043	0	2.00
	TOTALS		0	85,611		
	C - LEASE EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,327	9	1.00
2.00	OPERATION OF PLANT	7.00	0	553	0	2.00
3.00	MEDICAL RECORDS & LIBRARY	16.00	0	24,619	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	15,226	0	4.00
5.00	OPERATING ROOM	50.00	0	23	0	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,268	0	6.00
7.00	RESPIRATORY THERAPY	65.00	0	17,607	0	7.00
8.00	PHYSICAL THERAPY	66.00	0	365	0	8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	63,633	0	9.00
10.00	EMERGENCY	91.00	0	501	0	10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3,761	0	11.00
	TOTALS		0	131,883		
	D - INSURANCE EXPENSE					
1.00	AMBULANCE SERVICES	95.00	0	15,123	9	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	14,471	10	2.00
	TOTALS		0	29,594		
	F - GAIN/LOSS FIXED ASSETS					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	5,391	10	1.00
	TOTALS		0	5,391		
	G - DRUGS CHARGED					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,150	0	1.00
2.00	OPERATING ROOM	50.00	0	16,953	0	2.00
3.00	EMERGENCY	91.00	0	12,117	0	3.00
4.00	CAFETERIA	11.00	0	535	0	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	39,722	0	5.00
	TOTALS		0	70,477		
	J - BILLABLE SUPPLIES					
1.00	ADULTS & PEDIATRICS	30.00	0	6,206	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	242	0	2.00
3.00	OPERATING ROOM	50.00	0	36,965	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	56	0	4.00
5.00	RESPIRATORY THERAPY	65.00	0	46	0	5.00
6.00	PHYSICAL THERAPY	66.00	0	287	0	6.00
7.00	OCCUPATIONAL THERAPY	67.00	0	23	0	7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	8	0	8.00
9.00	CLINIC	90.00	0	153	0	9.00
10.00	EMERGENCY	91.00	0	2,454	0	10.00
11.00	AMBULANCE SERVICES	95.00	0	1,305	0	11.00
12.00	HOME HEALTH AGENCY	101.00	0	6,823	0	12.00
13.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	22,388	0	13.00
	TOTALS		0	76,956		
	K - PLANT COST					
1.00	AMBULANCE SERVICES	95.00	0	3,316	0	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	81,126	0	2.00
	TOTALS		0	84,442		
	M - YELLOW PAGES					
1.00	MARKETING	192.01	0	32,263	0	1.00
	TOTALS		0	32,263		
	P - IMPLANTABLE DEVICE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	49,722	0	1.00
	TOTALS		0	49,722		
	R - PAYROLL					
1.00	EMPLOYEE BENEFITS	4.00	0	4,381,374	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00

RECLASSIFICATIONS

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		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
25.00		0.00	0	0	0	25.00
26.00		0.00	0	0	0	26.00
	TOTALS		0	4,381,374		
	S - DEPRECIATION					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	136,316	9	1.00
	TOTALS		0	136,316		
500.00	Grand Total: Decreases		79,517	5,144,901		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part I | Date/Time Prepared: 5/30/2013 9:13 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	2,945,631	0	0	0	0	1.00
2.00	Land Improvements	1,494,906	0	0	0	0	2.00
3.00	Buildings and Fixtures	10,365,854	0	0	0	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	8,308,100	1,020,377	0	1,020,377	1,156,964	5.00
6.00	Movable Equipment	9,428,179	1,287,861	0	1,287,861	90,068	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,542,670	2,308,238	0	2,308,238	1,247,032	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,542,670	2,308,238	0	2,308,238	1,247,032	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	2,945,631	0	1.00
2.00	Land Improvements	1,494,906	0	2.00
3.00	Buildings and Fixtures	10,365,854	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	8,171,513	0	5.00
6.00	Movable Equipment	10,625,972	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	33,603,876	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	33,603,876	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part II | Date/Time Prepared: 5/30/2013 9:13 am

	Cost Center Description	SUMMARY OF CAPITAL Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,062,349	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,062,349	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,062,349	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	1,062,349	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-7 Part III | Date/Time Prepared: 5/30/2013 9:13 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	0	1	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	1	0	1	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,190,138	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	-12,184	105,436	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,177,954	105,436	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,190,138	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	93,252	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,283,390	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8 | Date/Time Prepared: 5/30/2013 9:13 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-21,874	NEW CAP REL COSTS-MVBLE EQUIP	2.00	10	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,786,211			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	28,570			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-50,188	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-86,229	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-1,568	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,748	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-150,321	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00	MISC INCOME	B	-28,833	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01			0		0.00	0	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8 | Date/Time Prepared: 5/30/2013 9:13 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
34.00	MISC INCOME	B	-4,074	AMBULANCE SERVICES	95.00	0	34.00
35.00	MISC INCOME	B	-1,808	HOME HEALTH AGENCY	101.00	0	35.00
36.00	HHA ADVERTISING	A	-766	HOME HEALTH AGENCY	101.00	0	36.00
37.00	RECRUITING	A	-54,991	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00			0		0.00	0	38.00
39.00	SWAP INTEREST	A	-12,184	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	39.00
40.00	PHONE	A	-22,764	OPERATION OF PLANT	7.00	0	40.00
41.00	PHONE	A	-5,212	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	41.00
42.00	DIETARY	B	-41	DIETARY	10.00	0	42.00
43.00	AHS	A	-3,718	ADMINISTRATIVE & GENERAL	5.00	0	43.00
45.00	NON-ALLOWABLE EXPENSE	A	-34,521	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	GAIN REPORTED ON EXPENSE	B	5,391	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	MISCELLANEOUS EXPENSE	A	-12,833	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	HOSPICE	A	-8	HOSPICE	116.00	0	45.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,247,931				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2013 9:13 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	2.00	NEW CAP REL COSTS-MVBLE EQUIP	AMBULANCE DEPRECIATION	32,619	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	MOBILE MRI	324,281	328,330	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	0		0	356,900	328,330	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	G	PERRY CO AMBULA	100.00		0.00	6.00
7.00	G	DSSI	100.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	OTHER				100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8-1 | Date/Time Prepared: 5/30/2013 9:13 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	32,619	10		1.00
2.00	-4,049	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	28,570			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office	Type of Business	
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00		6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8-2 | Date/Time Prepared: 5/30/2013 9:13 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	282,480	282,480	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	95,292	95,292	0	0	0	2.00
3.00	60.00	LABORATORY	18,000	0	18,000	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	191,264	191,264	0	0	0	4.00
5.00	91.00	EMERGENCY	1,537,200	1,217,175	320,025	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,124,236	1,786,211	338,025		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	50.00	OPERATING ROOM	0	0	0	282,480	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	95,292	2.00
3.00	60.00	LABORATORY	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	191,264	4.00
5.00	91.00	EMERGENCY	0	0	0	1,217,175	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	1,786,211	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/30/2013 9:13 am

		Physical Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		359	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		48	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		935	6.00
7.00	Standard travel expense rate		5.50	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	3,349.00	5,660.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.00	54.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.00	36.00	27.00			11.00
12.00	Number of travel hours (provider site)	0	133	174			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	4,955	8,271			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		241,128	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		305,640	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		546,768	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		546,768	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		546,768	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		12,924	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		12,924	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		1,975	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		14,899	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		9,576	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		9,396	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		18,972	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		18,972	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		1,728	36.00
37.00	Assistants (line 6 times column 3, line 11)		25,245	37.00
38.00	Subtotal (sum of lines 36 and 37)		26,973	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		5,407	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 5/30/2013 9:13 am

		Physical Therapy	Cost	
			1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.00	54.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		546,768	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		18,972	58.00
59.00	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		5,691	61.00
62.00	Supplies (see instructions)		7,241	62.00
63.00	Total allowance (sum of lines 57-62)		578,672	63.00
64.00	Total cost of outside supplier services (from your records)		96,470	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		12,924	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,975	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		14,899	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,975	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		18,972	101.01
101.02	Line 34 = sum of lines 27 and 31		20,947	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		18,972	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		18,972	102.02

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		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		254	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		481	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		277	6.00
7.00	Standard travel expense rate		5.50	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	621.00	3,020.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	68.25	51.19	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.13	34.13	25.60			11.00
12.00	Number of travel hours (provider site)	0	17	266			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	568	7,135			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		42,383	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		154,594	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		196,977	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		196,977	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		196,977	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		8,669	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		8,669	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		1,397	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		10,066	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		1,160	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		13,617	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		14,777	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		16,174	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		16,417	36.00
37.00	Assistants (line 6 times column 3, line 11)		7,091	37.00
38.00	Subtotal (sum of lines 36 and 37)		23,508	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		4,169	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00

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Occupational Therapy — Cost

						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					4,169	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists 1.00	Assistants 2.00	Aides 3.00	Trainees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	68.25	51.19	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		196,977	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		16,174	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		4,169	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		533	62.00
63.00	Total allowance (sum of lines 57-62)		217,853	63.00
64.00	Total cost of outside supplier services (from your records)		44,656	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		8,669	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,397	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		10,066	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,397	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		14,777	101.01
101.02	Line 34 = sum of lines 27 and 31		16,174	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		14,777	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		14,777	102.02

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		Speech Pathology	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		259	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		67	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.50	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors 1.00	Therapists 2.00	Assistants 3.00	Aides 4.00	Trainees 5.00	
9.00	Total hours worked	0.00	2,499.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	59.22	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	29.61	29.61	0.00			11.00
12.00	Number of travel hours (provider site)	0	12	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	985	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		147,991	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		147,991	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		147,991	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		0	22.00
23.00	Total salary equivalency (see instructions)		147,991	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		7,669	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		7,669	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		1,425	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		9,094	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		711	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		711	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		9,094	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		1,984	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		1,984	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		369	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		2,353	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00

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		Speech Pathology	Cost	
			1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	59.22	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		147,991	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		9,094	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		2,353	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		262	61.00
62.00	Supplies (see instructions)		2,654	62.00
63.00	Total allowance (sum of lines 57-62)		162,354	63.00
64.00	Total cost of outside supplier services (from your records)		4;020	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		7,669	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,425	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		9,094	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		1,425	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		711	101.01
101.02	Line 34 = sum of lines 27 and 31		2,136	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		711	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		711	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I | Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,190,138	1,190,138				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	93,252		93,252			2.00
4.00	00400	EMPLOYEE BENEFITS	36,496	11,702	917	49,115		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,055,490	142,311	11,151	7,335	6,216,287	5.00
7.00	00700	OPERATION OF PLANT	1,455,450	122,547	9,602	1,195	1,588,794	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	95,504	16,596	1,300	4	113,404	8.00
9.00	00900	HOUSEKEEPING	425,545	6,148	482	840	433,015	9.00
10.00	01000	DIETARY	499,529	79,298	6,213	705	585,745	10.00
11.00	01100	CAFETERIA	90,018	0	0	322	90,340	11.00
13.00	01300	NURSING ADMINISTRATION	676,186	10,785	845	2,244	690,060	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	445,361	23,539	1,844	713	471,457	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,567,418	232,774	18,238	6,302	2,824,732	30.00
31.00	03100	INTENSIVE CARE UNIT	314,108	24,213	1,897	1,099	341,317	31.00
43.00	04300	NURSERY	27,687	4,355	341	112	32,495	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	832,762	75,658	5,928	1,818	916,166	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,335	8,736	685	111	36,867	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,068,236	71,722	5,620	3,492	2,149,070	54.00
60.00	06000	LABORATORY	1,502,469	14,277	1,119	2,541	1,520,406	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	162,524	0	0	41	162,565	62.00
65.00	06500	RESPIRATORY THERAPY	910,638	30,590	2,397	1,932	945,557	65.00
66.00	06600	PHYSICAL THERAPY	419,884	54,816	4,295	87	479,082	66.00
67.00	06700	OCCUPATIONAL THERAPY	116,092	2,211	173	0	118,476	67.00
68.00	06800	SPEECH PATHOLOGY	148,151	2,211	173	0	150,535	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	398,838	2,966	232	186	402,222	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	59,768	0	0	0	59,768	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,392,669	14,762	1,157	335	2,408,923	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	322,802	44,637	3,498	834	371,771	90.00
91.00	09100	EMERGENCY	1,418,019	45,123	3,536	3,301	1,469,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,004,040	77,168	6,046	2,072	1,089,326	95.00
101.00	10100	HOME HEALTH AGENCY	778,278	7,927	621	1,189	788,015	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,534,687	1,127,072	88,310	38,810	26,456,374	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,030	786	0	10,816	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,713,782	53,036	4,156	10,163	4,781,137	192.00
192.01	19201	MARKETING	238,586	0	0	142	238,728	192.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	31,487,055	1,190,138	93,252	49,115	31,487,055	202.00

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,216,287					5.00
7.00	00700	OPERATION OF PLANT	390,823	1,979,617				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,896	35,961	177,261			8.00
9.00	00900	HOUSEKEEPING	106,516	13,321	11,927	564,779		9.00
10.00	01000	DIETARY	144,086	171,831	0	50,274	951,936	10.00
11.00	01100	CAFETERIA	22,222	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	169,746	23,370	0	6,838	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	115,972	51,006	0	14,923	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	694,847	504,392	69,655	147,574	929,875	30.00
31.00	03100	INTENSIVE CARE UNIT	83,960	52,466	2,520	15,351	22,061	31.00
43.00	04300	NURSERY	7,993	9,436	476	2,761	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	225,365	163,943	10,869	47,967	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,069	18,930	0	5,539	0	52.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I | Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	528,643	155,413	13,702	45,471	0	54.00
60.00	06000	LABORATORY	374,000	30,937	490	9,051	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	39,989	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	232,595	66,284	3,031	19,393	0	65.00
66.00	06600	PHYSICAL THERAPY	117,848	118,780	3,848	34,753	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	29,144	4,791	0	1,402	0	67.00
68.00	06800	SPEECH PATHOLOGY	37,030	4,791	0	1,402	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	98,941	6,427	0	1,880	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	14,702	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	592,564	31,988	0	9,359	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	91,451	96,724	1,505	28,300	0	90.00
91.00	09100	EMERGENCY	361,596	97,776	58,954	28,607	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	267,960	167,215	185	48,924	0	95.00
101.00	10100	HOME HEALTH AGENCY	193,841	17,177	0	5,026	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,978,799	1,842,959	177,162	524,795	951,936	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,661	21,734	0	6,359	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,176,103	114,924	99	33,625	0	192.00
192.01	19201	MARKETING	58,724	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	6,216,287	1,979,617	177,261	564,779	951,936	202.00

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	112,562					11.00
13.00	01300	NURSING ADMINISTRATION	7,360	897,374				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,405	0	657,763			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,161	486,698	120,912	5,811,846	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,423	64,919	0	587,017	0	31.00
43.00	04300	NURSERY	489	7,184	0	60,834	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,832	70,928	0	1,440,070	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	472	6,923	0	77,800	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,159	0	169,278	3,075,736	0	54.00
60.00	06000	LABORATORY	13,082	0	166,859	2,114,825	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	187	0	0	202,741	0	62.00
65.00	06500	RESPIRATORY THERAPY	8,312	0	38,692	1,313,864	0	65.00
66.00	06600	PHYSICAL THERAPY	837	0	29,019	784,167	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	153,813	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	14,509	208,267	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	748	0	0	510,218	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	74,470	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,332	0	0	3,045,166	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4,245	62,307	26,601	682,904	0	90.00
91.00	09100	EMERGENCY	13,518	198,415	91,893	2,320,738	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	1,573,610	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,004,059	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	112,562	897,374	657,763	25,042,145	0	118.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part I | Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	41,570	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	6,105,888	0	192.00
192.01	19201	MARKETING	0	0	0	297,452	0	192.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	112,562	897,374	657,763	31,487,055	0	202.00
		Cost Center Description	Total					
			26.00					
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,811,846					30.00
31.00	03100	INTENSIVE CARE UNIT	587,017					31.00
43.00	04300	NURSERY	60,834					43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,440,070					50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	77,800					52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,075,736					54.00
60.00	06000	LABORATORY	2,114,825					60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	202,741					62.00
65.00	06500	RESPIRATORY THERAPY	1,313,864					65.00
66.00	06600	PHYSICAL THERAPY	784,167					66.00
67.00	06700	OCCUPATIONAL THERAPY	153,813					67.00
68.00	06800	SPEECH PATHOLOGY	208,267					68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	510,218					71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	74,470					72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,045,166					73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	682,904					90.00
91.00	09100	EMERGENCY	2,320,738					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,573,610					95.00
101.00	10100	HOME HEALTH AGENCY	1,004,059					101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0					116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,042,145					118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	41,570					190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,105,888					192.00
192.01	19201	MARKETING	297,452					192.01
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0					201.00
202.00		TOTAL (sum lines 118-201)	31,487,055					202.00

		Cost Center Description	CAPITAL RELATED COSTS					
			Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS	0	11,702	917	12,619	12,619	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	142,311	11,151	153,462	1,884	5.00
7.00	00700	OPERATION OF PLANT	0	122,547	9,602	132,149	307	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,596	1,300	17,896	1	8.00
9.00	00900	HOUSEKEEPING	0	6,148	482	6,630	216	9.00
10.00	01000	DIETARY	0	79,298	6,213	85,511	181	10.00
11.00	01100	CAFETERIA	0	0	0	0	83	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,785	845	11,630	576	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,539	1,844	25,383	183	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	232,774	18,238	251,012	1,619	30.00
31.00	03100	INTENSIVE CARE UNIT	0	24,213	1,897	26,110	282	31.00
43.00	04300	NURSERY	0	4,355	341	4,696	29	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	75,658	5,928	81,586	467	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,736	685	9,421	28	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	71,722	5,620	77,342	897	54.00
60.00	06000	LABORATORY	0	14,277	1,119	15,396	653	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	10	62.00
65.00	06500	RESPIRATORY THERAPY	0	30,590	2,397	32,987	496	65.00
66.00	06600	PHYSICAL THERAPY	0	54,816	4,295	59,111	22	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,211	173	2,384	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,211	173	2,384	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,966	232	3,198	48	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	14,762	1,157	15,919	86	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	44,637	3,498	48,135	214	90.00
91.00	09100	EMERGENCY	0	45,123	3,536	48,659	848	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	77,168	6,046	83,214	532	95.00
101.00	10100	HOME HEALTH AGENCY	0	7,927	621	8,548	306	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,127,072	88,310	1,215,382	9,968	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,030	786	10,816	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	53,036	4,156	57,192	2,614	192.00
192.01	19201	MARKETING	0	0	0	0	37	192.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,190,138	93,252	1,283,390	12,619	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			11.00	13.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	638					11.00
13.00	01300	NURSING ADMINISTRATION	42	18,313				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25	0	32,467			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	188	9,932	5,968	434,062	0	30.00
31.00	03100	INTENSIVE CARE UNIT	25	1,325	0	36,613	0	31.00
43.00	04300	NURSERY	3	147	0	5,868	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	27	1,447	0	103,246	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3	141	0	11,297	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	80	0	8,356	113,644	0	54.00
60.00	06000	LABORATORY	74	0	8,236	36,178	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1	0	0	1,010	0	62.00
65.00	06500	RESPIRATORY THERAPY	47	0	1,910	46,784	0	65.00
66.00	06600	PHYSICAL THERAPY	5	0	1,432	73,241	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	3,486	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	716	4,399	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4	0	0	6,224	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	367	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13	0	0	33,321	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	24	1,272	1,313	60,968	0	90.00
91.00	09100	EMERGENCY	77	4,049	4,536	81,876	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	103,507	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	15,038	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	638	18,313	32,467	1,171,129	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	12,577	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	98,180	0	192.00
192.01	19201	MARKETING	0	0	0	1,504	0	192.01
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	638	18,313	32,467	1,283,390	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B Part II Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	434,062		30.00
31.00	03100	INTENSIVE CARE UNIT	36,613		31.00
43.00	04300	NURSERY	5,868		43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	103,246		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,297		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	113,644		54.00
60.00	06000	LABORATORY	36,178		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,010		62.00
65.00	06500	RESPIRATORY THERAPY	46,784		65.00
66.00	06600	PHYSICAL THERAPY	73,241		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,486		67.00
68.00	06800	SPEECH PATHOLOGY	4,399		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,224		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	367		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,321		73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	60,968		90.00
91.00	09100	EMERGENCY	81,876		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	103,507		95.00
101.00	10100	HOME HEALTH AGENCY	15,038		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,171,129		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	12,577		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	98,180		192.00
192.01	19201	MARKETING	1,504		192.01
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	1,283,390		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	88,279					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		88,279				2.00
4.00	00400	EMPLOYEE BENEFITS	868	868	12,122,328			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,556	10,556	1,810,118	-6,216,287	25,270,768	5.00
7.00	00700	OPERATION OF PLANT	9,090	9,090	294,921	0	1,588,794	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,231	1,231	908	0	113,404	8.00
9.00	00900	HOUSEKEEPING	456	456	207,425	0	433,015	9.00
10.00	01000	DIETARY	5,882	5,882	173,894	0	585,745	10.00
11.00	01100	CAFETERIA	0	0	79,517	0	90,340	11.00
13.00	01300	NURSING ADMINISTRATION	800	800	553,748	0	690,060	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,746	1,746	176,080	0	471,457	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,266	17,266	1,555,228	0	2,824,732	30.00
31.00	03100	INTENSIVE CARE UNIT	1,796	1,796	271,198	0	341,317	31.00
43.00	04300	NURSERY	323	323	27,658	0	32,495	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,612	5,612	448,693	0	916,166	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	648	648	27,307	0	36,867	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,320	5,320	861,744	0	2,149,070	54.00
60.00	06000	LABORATORY	1,059	1,059	627,194	0	1,520,406	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	10,005	0	162,565	62.00
65.00	06500	RESPIRATORY THERAPY	2,269	2,269	476,819	0	945,557	65.00
66.00	06600	PHYSICAL THERAPY	4,066	4,066	21,380	0	479,082	66.00
67.00	06700	OCCUPATIONAL THERAPY	164	164	0	0	118,476	67.00
68.00	06800	SPEECH PATHOLOGY	164	164	0	0	150,535	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	220	220	45,916	0	402,222	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	59,768	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,095	1,095	82,659	0	2,408,923	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,311	3,311	205,846	0	371,771	90.00
91.00	09100	EMERGENCY	3,347	3,347	814,578	0	1,469,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,724	5,724	511,259	0	1,089,326	95.00
101.00	10100	HOME HEALTH AGENCY	588	588	293,494	0	788,015	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	83,601	83,601	9,577,589	-6,216,287	20,240,087	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	744	744	0	0	10,816	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,934	3,934	2,509,621	0	4,781,137	192.00
192.01	19201	MARKETING	0	0	35,118	0	238,728	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,190,138	93,252	49,115		6,216,287	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.481553	1.056333	0.004052		0.245987	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			12,619		155,346	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001041		0.006147	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	67,765					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,231	24,968				8.00
9.00	00900	HOUSEKEEPING	456	1,680	66,078			9.00
10.00	01000	DIETARY	5,882	0	5,882	26,580		10.00
11.00	01100	CAFETERIA	0	0	0	0	12,648	11.00
13.00	01300	NURSING ADMINISTRATION	800	0	800	0	827	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,746	0	1,746	0	495	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,266	9,811	17,266	25,964	3,726	30.00
31.00	03100	INTENSIVE CARE UNIT	1,796	355	1,796	616	497	31.00
43.00	04300	NURSERY	323	67	323	0	55	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,612	1,531	5,612	0	543	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	648	0	648	0	53	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,320	1,930	5,320	0	1,591	54.00
60.00	06000	LABORATORY	1,059	69	1,059	0	1,470	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	21	62.00
65.00	06500	RESPIRATORY THERAPY	2,269	427	2,269	0	934	65.00
66.00	06600	PHYSICAL THERAPY	4,066	542	4,066	0	94	66.00
67.00	06700	OCCUPATIONAL THERAPY	164	0	164	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	164	0	164	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	220	0	220	0	84	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,095	0	1,095	0	262	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	3,311	212	3,311	0	477	90.00
91.00	09100	EMERGENCY	3,347	8,304	3,347	0	1,519	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,724	26	5,724	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	588	0	588	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	63,087	24,954	61,400	26,580	12,648	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	744	0	744	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,934	14	3,934	0	0	192.00
192.01	19201	MARKETING	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,979,617	177,261	564,779	951,936	112,562	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.212971	7.099527	8.547156	35.813995	8.899589	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	142,222	21,178	11,890	102,696	638	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.098753	0.848206	0.179939	3.863657	0.050443	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet B-1 | Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			13.00	16.00	
		GENERAL SERVICE COST CENTERS			
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION	6,870		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	272	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,726	50	30.00
31.00	03100	INTENSIVE CARE UNIT	497	0	31.00
43.00	04300	NURSERY	55	0	43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	543	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	53	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	70	54.00
60.00	06000	LABORATORY	0	69	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	16	65.00
66.00	06600	PHYSICAL THERAPY	0	12	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	6	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	477	11	90.00
91.00	09100	EMERGENCY	1,519	38	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,870	272	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	MARKETING	0	0	192.01
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	897,374	657,763	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	130.622125	2,418.246324	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	18,313	32,467	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.665648	119.363971	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I | Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII Costs Total Costs	RCE Disallowance	Hospital Total Costs	Cost Charges Inpatient	
			1.00	2.00	3.00	4.00	5.00	6.00	
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,811,846		5,811,846	0	0	3,258,198	30.00
31.00	03100	INTENSIVE CARE UNIT	587,017		587,017	0	0	972,102	31.00
43.00	04300	NURSERY	60,834		60,834	0	0	107,730	43.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,440,070		1,440,070	0	0	784,238	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	77,800		77,800	0	0	234,869	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,075,736		3,075,736	0	0	2,282,061	54.00
60.00	06000	LABORATORY	2,114,825		2,114,825	0	0	2,271,622	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	202,741		202,741	0	0	216,725	62.00
65.00	06500	RESPIRATORY THERAPY	1,313,864	0	1,313,864	0	0	1,619,691	65.00
66.00	06600	PHYSICAL THERAPY	784,167	0	784,167	0	0	388,966	66.00
67.00	06700	OCCUPATIONAL THERAPY	153,813	0	153,813	0	0	221,074	67.00
68.00	06800	SPEECH PATHOLOGY	208,267	0	208,267	0	0	73,743	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	510,218		510,218	0	0	2,106,725	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	74,470		74,470	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,045,166		3,045,166	0	0	5,910,544	73.00
		OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	682,904		682,904	0	0	2,723	90.00
91.00	09100	EMERGENCY	2,320,738		2,320,738	0	0	289,539	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	541,493		541,493		0	29,263	92.00
		OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,573,610		1,573,610	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	1,004,059		1,004,059		0	0	101.00
		SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE							113.00
116.00	11600	HOSPICE	0		0		0	0	116.00
200.00		Subtotal (see instructions)	25,583,638	0	25,583,638	0	0	20,769,813	200.00
201.00		Less Observation Beds	541,493		541,493		0		201.00
202.00		Total (see instructions)	25,042,145	0	25,042,145	0	0	20,769,813	202.00

		Cost Center Description	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
			7.00	8.00	9.00	10.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		3,258,198				30.00
31.00	03100	INTENSIVE CARE UNIT		972,102				31.00
43.00	04300	NURSERY		107,730				43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,883,397	4,667,635	0.308522	0.000000	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	158,495	393,364	0.197781	0.000000	0.000000	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,658,249	14,940,310	0.205868	0.000000	0.000000	54.00
60.00	06000	LABORATORY	6,419,131	8,690,753	0.243342	0.000000	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	164,614	381,339	0.531656	0.000000	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	1,751,283	3,370,974	0.389758	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,491,421	1,880,387	0.417024	0.000000	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	346,930	568,004	0.270796	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	342,267	416,010	0.500630	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,483,944	4,590,669	0.111142	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	53,650	53,650	1.388071	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,775,335	12,685,879	0.240044	0.000000	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	432,382	435,105	1.569515	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	5,333,194	5,622,733	0.412742	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	330,536	359,799	1.504988	0.000000	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,273,176	2,273,176	0.692252	0.000000	0.000000	95.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I | Date/Time Prepared: 5/30/2013 9:13 am

Title XVIII | Hospital

		Cost Center Description	Charges Outpatient	Charges Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	Cost	
			7.00	8.00	9.00	10.00	11.00		
101.00	10100	HOME HEALTH AGENCY	2,121,397	2,121,397					101.00
		SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE							113.00
116.00	11600	HOSPICE	0	0					116.00
200.00		Subtotal (see instructions)	47,019,401	67,789,214					200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	47,019,401	67,789,214					202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I | Date/Time Prepared: 5/30/2013 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Total Costs	Charges Inpatient	
			1.00	2.00	3.00	4.00	5.00	6.00	
		INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,811,846		5,811,846	0	5,811,846	3,258,198	30.00
31.00	03100	INTENSIVE CARE UNIT	587,017		587,017	0	587,017	972,102	31.00
43.00	04300	NURSERY	60,834		60,834	0	60,834	107,730	43.00
		ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,440,070		1,440,070	0	1,440,070	784,238	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	77,800		77,800	0	77,800	234,869	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,075,736		3,075,736	0	3,075,736	2,282,061	54.00
60.00	06000	LABORATORY	2,114,825		2,114,825	0	2,114,825	2,271,622	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	202,741		202,741	0	202,741	216,725	62.00
65.00	06500	RESPIRATORY THERAPY	1,313,864	0	1,313,864	0	1,313,864	1,619,691	65.00
66.00	06600	PHYSICAL THERAPY	784,167	0	784,167	0	784,167	388,966	66.00
67.00	06700	OCCUPATIONAL THERAPY	153,813	0	153,813	0	153,813	221,074	67.00
68.00	06800	SPEECH PATHOLOGY	208,267	0	208,267	0	208,267	73,743	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	510,218		510,218	0	510,218	2,106,725	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	74,470		74,470	0	74,470	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,045,166		3,045,166	0	3,045,166	5,910,544	73.00
		OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	682,904		682,904	0	682,904	2,723	90.00
91.00	09100	EMERGENCY	2,320,738		2,320,738	0	2,320,738	289,539	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	541,493		541,493		541,493	29,263	92.00
		OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,573,610		1,573,610	0	1,573,610	0	95.00
101.00	10100	HOME HEALTH AGENCY	1,004,059		1,004,059		1,004,059	0	101.00
		SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE							113.00
116.00	11600	HOSPICE	0		0		0	0	116.00
200.00		Subtotal (see instructions)	25,583,638	0	25,583,638	0	25,583,638	20,769,813	200.00
201.00		Less Observation Beds	541,493		541,493		541,493		201.00
202.00		Total (see instructions)	25,042,145	0	25,042,145	0	25,042,145	20,769,813	202.00

		Cost Center Description	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
			7.00	8.00	9.00	10.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		3,258,198				30.00
31.00	03100	INTENSIVE CARE UNIT		972,102				31.00
43.00	04300	NURSERY		107,730				43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,883,397	4,667,635	0.308522	0.000000	0.308522	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	158,495	393,364	0.197781	0.000000	0.197781	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,658,249	14,940,310	0.205868	0.000000	0.205868	54.00
60.00	06000	LABORATORY	6,419,131	8,690,753	0.243342	0.000000	0.243342	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	164,614	381,339	0.531656	0.000000	0.531656	62.00
65.00	06500	RESPIRATORY THERAPY	1,751,283	3,370,974	0.389758	0.000000	0.389758	65.00
66.00	06600	PHYSICAL THERAPY	1,491,421	1,880,387	0.417024	0.000000	0.417024	66.00
67.00	06700	OCCUPATIONAL THERAPY	346,930	568,004	0.270796	0.000000	0.270796	67.00
68.00	06800	SPEECH PATHOLOGY	342,267	416,010	0.500630	0.000000	0.500630	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,483,944	4,590,669	0.111142	0.000000	0.111142	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	53,650	53,650	1.388071	0.000000	1.388071	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,775,335	12,685,879	0.240044	0.000000	0.240044	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	432,382	435,105	1.569515	0.000000	1.569515	90.00
91.00	09100	EMERGENCY	5,333,194	5,622,733	0.412742	0.000000	0.412742	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	330,536	359,799	1.504988	0.000000	1.504988	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,273,176	2,273,176	0.692252	0.000000	0.692252	95.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part I | Date/Time Prepared: 5/30/2013 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Outpatient	Charges Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
			7.00	8.00	9.00	10.00	11.00	
101.00	10100	HOME HEALTH AGENCY	2,121,397	2,121,397				101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0				116.00
200.00		Subtotal (see instructions)	47,019,401	67,789,214				200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	47,019,401	67,789,214				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part II | Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Title XIX Capital Cost (Wkst. B, Part II col. 26)	Title XIX Operating Cost Net of Capital Cost (col. 1 - col. 2)	Hospital Capital Reduction	PPS Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,440,070	103,246	1,336,824	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	77,800	11,297	66,503	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,075,736	113,644	2,962,092	0	0	54.00
60.00	06000	LABORATORY	2,114,825	36,178	2,078,647	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	202,741	1,010	201,731	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	1,313,864	46,784	1,267,080	0	0	65.00
66.00	06600	PHYSICAL THERAPY	784,167	73,241	710,926	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	153,813	3,486	150,327	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	208,267	4,399	203,868	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	510,218	6,224	503,994	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	74,470	367	74,103	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,045,166	33,321	3,011,845	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	682,904	60,968	621,936	0	0	90.00
91.00	09100	EMERGENCY	2,320,738	81,876	2,238,862	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	541,493	0	541,493	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,573,610	103,507	1,470,103	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	1,004,059	15,038	989,021	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
200.00		Subtotal (sum of lines 50 thru 199)	19,123,941	694,586	18,429,355	0	0	200.00
201.00		Less Observation Beds	541,493	0	541,493	0	0	201.00
202.00		Total (line 200 minus line 201)	18,582,448	694,586	17,887,862	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet C Part II | Date/Time Prepared: 5/30/2013 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,440,070	4,667,635	0.308522		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	77,800	393,364	0.197781		52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,075,736	14,940,310	0.205868		54.00
60.00	06000	LABORATORY	2,114,825	8,690,753	0.243342		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	202,741	381,339	0.531656		62.00
65.00	06500	RESPIRATORY THERAPY	1,313,864	3,370,974	0.389758		65.00
66.00	06600	PHYSICAL THERAPY	784,167	1,880,387	0.417024		66.00
67.00	06700	OCCUPATIONAL THERAPY	153,813	568,004	0.270796		67.00
68.00	06800	SPEECH PATHOLOGY	208,267	416,010	0.500630		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	510,218	4,590,669	0.111142		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	74,470	53,650	1.388071		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,045,166	12,685,879	0.240044		73.00
		OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	682,904	435,105	1.569515		90.00
91.00	09100	EMERGENCY	2,320,738	5,622,733	0.412742		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	541,493	359,799	1.504988		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,573,610	2,273,176	0.692252		95.00
101.00	10100	HOME HEALTH AGENCY	1,004,059	2,121,397	0.473301		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0.000000		116.00
200.00		Subtotal (sum of lines 50 thru 199)	19,123,941	63,451,184			200.00
201.00		Less Observation Beds	541,493	0			201.00
202.00		Total (line 200 minus line 201)	18,582,448	63,451,184			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part II Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Title XVIII Total Charges (from Wkst. C, Part I, col. 8)	Title XVIII Ratio of Cost to Charges (col. 1 ÷ col. 2)	Hospital Inpatient Program Charges	Cost Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	103,246	4,667,635	0.022120	173,120	3,829	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,297	393,364	0.028719	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	113,644	14,940,310	0.007607	862,980	6,565	54.00
60.00	06000	LABORATORY	36,178	8,690,753	0.004163	1,327,946	5,528	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,010	381,339	0.002649	116,962	310	62.00
65.00	06500	RESPIRATORY THERAPY	46,784	3,370,974	0.013878	1,222,088	16,960	65.00
66.00	06600	PHYSICAL THERAPY	73,241	1,880,387	0.038950	202,038	7,869	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,486	568,004	0.006137	99,232	609	67.00
68.00	06800	SPEECH PATHOLOGY	4,399	416,010	0.010574	61,624	652	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,224	4,590,669	0.001356	1,107,920	1,502	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	367	53,650	0.006841	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,321	12,685,879	0.002627	3,268,489	8,586	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	60,968	435,105	0.140122	226	32	90.00
91.00	09100	EMERGENCY	81,876	5,622,733	0.014562	9,838	143	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	359,799	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	576,041	59,056,611		8,452,463	52,585	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	Title XVIII Non Physician Anesthetist Cost	Nursing School	Allied Health	Hospital All Other Medical Education Cost	Cost Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XVIII Total Charges (from Wkst. C, Part I, col. 8)	Title XVIII Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,667,635	0.000000	0.000000	173,120	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	393,364	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,940,310	0.000000	0.000000	862,980	54.00
60.00	06000	LABORATORY	0	8,690,753	0.000000	0.000000	1,327,946	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	381,339	0.000000	0.000000	116,962	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,370,974	0.000000	0.000000	1,222,088	65.00
66.00	06600	PHYSICAL THERAPY	0	1,880,387	0.000000	0.000000	202,038	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	568,004	0.000000	0.000000	99,232	67.00
68.00	06800	SPEECH PATHOLOGY	0	416,010	0.000000	0.000000	61,624	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,590,669	0.000000	0.000000	1,107,920	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	53,650	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,685,879	0.000000	0.000000	3,268,489	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	435,105	0.000000	0.000000	226	90.00
91.00	09100	EMERGENCY	0	5,622,733	0.000000	0.000000	9,838	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	359,799	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	59,056,611			8,452,463	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/30/2013 9:13 am

Title XVIII | Hospital

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.308522	0	1,203,004	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.197781	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205868	0	4,185,206	0	0	54.00
60.00	06000	LABORATORY	0.243342	0	2,643,782	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.531656	0	132,584	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.389758	0	748,413	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.417024	0	566,342	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.270796	0	75,235	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.500630	0	29,918	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.111142	0	753,194	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.388071	0	52,725	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240044	0	3,769,963	14,067	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.569515	0	39,004	0	0	90.00
91.00	09100	EMERGENCY	0.412742	0	1,125,962	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.504988	0	302,992	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.692252		0			95.00
200.00		Subtotal (see instructions)		0	15,628,324	14,067	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	15,628,324	14,067	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V | Date/Time Prepared: 5/30/2013 9:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	371,153	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	861,600	0	54.00
60.00	06000	LABORATORY	643,343	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	70,489	0	62.00
65.00	06500	RESPIRATORY THERAPY	291,700	0	65.00
66.00	06600	PHYSICAL THERAPY	236,178	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,373	0	67.00
68.00	06800	SPEECH PATHOLOGY	14,978	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	83,711	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	73,186	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	904,957	3,377	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	61,217	0	90.00
91.00	09100	EMERGENCY	464,732	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	455,999	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	4,553,616	3,377	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	4,553,616	3,377	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V | Date/Time Prepared: 5/30/2013 9:13 am

Component CCN: 15Z322 | Title XVIII | Swing Beds - SNF

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Cost: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.308522	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.197781	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205868	0	0	0	0	54.00
60.00	06000	LABORATORY	0.243342	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.531656	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.389758	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.417024	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.270796	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.500630	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.111142	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.388071	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240044	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.569515	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.412742	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.504988	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.692252		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151322 | Component CCN: 15Z322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V | Date/Time Prepared: 5/30/2013 9:13 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part I | Date/Time Prepared: 5/30/2013 9:13 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	434,062	57,267	376,795	4,174	90.27	30.00
31.00	INTENSIVE CARE UNIT	36,613		36,613	248	147.63	31.00
43.00	NURSERY	5,868		5,868	164	35.78	43.00
200.00	Total (lines 30-199)	476,543		419,276	4,586		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	382	34,483	30.00
31.00	INTENSIVE CARE UNIT	11	1,624	31.00
43.00	NURSERY	97	3,471	43.00
200.00	Total (lines 30-199)	490	39,578	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part II Date/Time Prepared: 5/30/2013 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	103,246	4,667,635	0.022120	223,000	4,933	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,297	393,364	0.028719	133,538	3,835	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	113,644	14,940,310	0.007607	200,677	1,527	54.00
60.00	06000	LABORATORY	36,178	8,690,753	0.004163	185,532	772	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	1,010	381,339	0.002649	8,612	23	62.00
65.00	06500	RESPIRATORY THERAPY	46,784	3,370,974	0.013878	161,498	2,241	65.00
66.00	06600	PHYSICAL THERAPY	73,241	1,880,387	0.038950	11,168	435	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,486	568,004	0.006137	8,150	50	67.00
68.00	06800	SPEECH PATHOLOGY	4,399	416,010	0.010574	1,911	20	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,224	4,590,669	0.001356	184,072	250	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	367	53,650	0.006841	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	33,321	12,685,879	0.002627	479,903	1,261	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	60,968	435,105	0.140122	652	91	90.00
91.00	09100	EMERGENCY	81,876	5,622,733	0.014562	47,176	687	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	46,588	359,799	0.129483	12,635	1,636	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	622,629	59,056,611		1,658,524	17,761	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part III Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	Title XIX Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital Swing-Bed Adjustment Amount (see instructions)	PPS Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,174	0.00	382	0	30.00
31.00	03100	INTENSIVE CARE UNIT	248	0.00	11	0	31.00
43.00	04300	NURSERY	164	0.00	97	0	43.00
200.00		Total (lines 30-199)	4,586		490	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	Title XIX Non Physician Anesthetist Cost	Nursing School	Allied Health	Hospital All Other Medical Education Cost	PPS Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Title XIX Total Charges (from Wkst. C, Part I, col. 8)	Title XIX Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,667,635	0.000000	0.000000	223,000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	393,364	0.000000	0.000000	133,538	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,940,310	0.000000	0.000000	200,677	54.00
60.00	06000	LABORATORY	0	8,690,753	0.000000	0.000000	185,532	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	381,339	0.000000	0.000000	8,612	62.00
65.00	06500	RESPIRATORY THERAPY	0	3,370,974	0.000000	0.000000	161,498	65.00
66.00	06600	PHYSICAL THERAPY	0	1,880,387	0.000000	0.000000	11,168	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	568,004	0.000000	0.000000	8,150	67.00
68.00	06800	SPEECH PATHOLOGY	0	416,010	0.000000	0.000000	1,911	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,590,669	0.000000	0.000000	184,072	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	53,650	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,685,879	0.000000	0.000000	479,903	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	435,105	0.000000	0.000000	652	90.00
91.00	09100	EMERGENCY	0	5,622,733	0.000000	0.000000	47,176	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	359,799	0.000000	0.000000	12,635	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	59,056,611			1,658,524	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part IV | Date/Time Prepared: 5/30/2013 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V | Date/Time Prepared: 5/30/2013 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.308522	0	458,435	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.197781	0	95,771	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205868	0	1,501,801	0	0	54.00
60.00	06000	LABORATORY	0.243342	0	829,764	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.531656	0	7,016	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.389758	0	163,777	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.417024	0	125,542	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.270796	0	84,790	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.500630	0	161,565	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.111142	0	392,074	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.388071	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240044	0	945,427	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	1.569515	0	36,170	0	0	90.00
91.00	09100	EMERGENCY	0.412742	0	1,108,524	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.504988	0	27,544	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.692252	0	106,982			95.00
200.00		Subtotal (see instructions)		0	6,045,182	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	6,045,182	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D Part V Date/Time Prepared: 5/30/2013 9:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Costs Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Costs Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	141,437	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,942	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	309,173	0	54.00
60.00	06000	LABORATORY	201,916	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	3,730	0	62.00
65.00	06500	RESPIRATORY THERAPY	63,833	0	65.00
66.00	06600	PHYSICAL THERAPY	52,354	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	22,961	0	67.00
68.00	06800	SPEECH PATHOLOGY	80,884	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,576	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	226,944	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	56,769	0	90.00
91.00	09100	EMERGENCY	457,534	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	41,453	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	74,059		95.00
200.00		Subtotal (see instructions)	1,795,565	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	1,795,565	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/30/2013 9:13 am

Title XVIII | Hospital

	Cost Center Description	Cost	
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,836	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,174	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,726	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	631	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	31	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,459	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	631	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,811,846	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	4,092	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	766,775	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,045,071	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed charges)	3,365,928	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	3,365,928	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.498865	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	903.36	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,045,071	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,208.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,972,169	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,972,169	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/30/2013 9:13 am

	Cost Center Description	Title XVIII Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Cost Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	587,017	248	2,367.00	168	397,656	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,146,830	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,516,655	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	762,683	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	762,683	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	448	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,208.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	541,493	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/30/2013 9:13 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/30/2013 9:13 am

Title XIX | Hospital | PPS

	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS			
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,836	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,174	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		3,726	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		631	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		31	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		382	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		31	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		164	15.00
16.00	Nursery days (title V or XIX only)		97	16.00
	SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		132.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		132.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,811,846	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		4,092	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		766,775	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,045,071	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,365,928	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,365,928	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.498865	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		903.36	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,045,071	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,208.69	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		461,720	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		461,720	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/30/2013 9:13 am

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Title XIX Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	PPS Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	60,834	164	370.94	97	35,981	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	587,017	248	2,367.00	11	26,037	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	432,184	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	955,922	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	39,578	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	17,761	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	57,339	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	898,583	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	4,092	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	4,092	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	448	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,208.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	541,493	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-1 | Date/Time Prepared: 5/30/2013 9:13 am

Title XIX

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Hospital Total Observation Bed Cost (from line 89)	PPS Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	434,062	5,045,071	0.086037	541,493	46,588	90.00
91.00	Nursing School cost	0	5,045,071	0.000000	541,493	0	91.00
92.00	Allied health cost	0	5,045,071	0.000000	541,493	0	92.00
93.00	All other Medical Education	0	5,045,071	0.000000	541,493	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3 | Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	Title XVIII Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,165,316		30.00
31.00	03100	INTENSIVE CARE UNIT		302,232		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.308522	173,120	53,411	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.197781	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205868	862,980	177,660	54.00
60.00	06000	LABORATORY	0.243342	1,327,946	323,145	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.531656	116,962	62,184	62.00
65.00	06500	RESPIRATORY THERAPY	0.389758	1,222,088	476,319	65.00
66.00	06600	PHYSICAL THERAPY	0.417024	202,038	84,255	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.270796	99,232	26,872	67.00
68.00	06800	SPEECH PATHOLOGY	0.500630	61,624	30,851	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.111142	1,107,920	123,136	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.388071	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240044	3,268,489	784,581	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.569515	226	355	90.00
91.00	09100	EMERGENCY	0.412742	9,838	4,061	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.504988	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		8,452,463	2,146,830	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		8,452,463		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151322 | Component CCN: 15Z322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3 | Date/Time Prepared: 5/30/2013 9:13 am

Title XVIII | Swing Beds - SNF

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.308522	128	39	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.197781	0	0	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205868	15,708	3,234	54.00
60.00	06000	LABORATORY	0.243342	81,845	19,916	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.531656	1,230	654	62.00
65.00	06500	RESPIRATORY THERAPY	0.389758	71,691	27,942	65.00
66.00	06600	PHYSICAL THERAPY	0.417024	148,235	61,818	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.270796	101,968	27,613	67.00
68.00	06800	SPEECH PATHOLOGY	0.500630	8,070	4,040	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.111142	120,152	13,354	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.388071	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240044	424,443	101,885	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.569515	0	0	90.00
91.00	09100	EMERGENCY	0.412742	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.504988	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		973,470	260,495	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		973,470		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet D-3 | Date/Time Prepared: 5/30/2013 9:13 am

		Cost Center Description	Title XIX Ratio of Cost To Charges	Hospital Inpatient Program Charges	PPS Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		286,991		30.00
31.00	03100	INTENSIVE CARE UNIT		47,689		31.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.308522	223,000	68,800	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.197781	133,538	26,411	52.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.205868	200,677	41,313	54.00
60.00	06000	LABORATORY	0.243342	185,532	45,148	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.531656	8,612	4,579	62.00
65.00	06500	RESPIRATORY THERAPY	0.389758	161,498	62,945	65.00
66.00	06600	PHYSICAL THERAPY	0.417024	11,168	4,657	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.270796	8,150	2,207	67.00
68.00	06800	SPEECH PATHOLOGY	0.500630	1,911	957	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.111142	184,072	20,458	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1.388071	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240044	479,903	115,198	73.00
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.569515	652	1,023	90.00
91.00	09100	EMERGENCY	0.412742	47,176	19,472	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.504988	12,635	19,016	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,658,524	432,184	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,658,524		202.00

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,556,993	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,556,993	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,602,563	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	56,570	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,568,396	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	1,977,597	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,977,597	30.00
31.00	Primary payer payments	827	31.00
32.00	Subtotal (line 30 minus line 31)	1,976,770	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	358,878	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	358,878	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	166,730	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)	2,335,648	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	AB Re-billing demo amount (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)	2,335,648	40.00
41.00	Interim payments	2,276,803	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)	58,845	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-1 Part I | Date/Time Prepared: 5/30/2013 9:13 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,501,317		1,877,403	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/05/2012	105,800	09/05/2012	399,400	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		105,800		399,400	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,607,117		2,276,803	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		484,856		58,845	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		5,091,973		2,335,648	7.00

			Contractor Number	Date (Mo/Day/Yr)	
			1.00	2.00	
8.00	Name of Contractor	0			8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 151322 | Period: From 01/01/2012 | Worksheet E-1 Part I
Component CCN: 15Z322 | To 12/31/2012 | Date/Time Prepared: 5/30/2013 9:13 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		857,892		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	09/05/2012	50,600		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		50,600		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		908,492		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		118,415		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,026,907		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
8.00	Name of Contractor	0		1.00	2.00	8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-1 Part II | Date/Time Prepared: 5/30/2013 9:13 am

Title XVIII | Hospital | Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	1,209	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	2,627	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	122	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	3,974	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	67,789,214	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	2,143,877	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	908,819	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	831,021	8.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	822,299	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)	8,722	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-2
Component CCN: 15Z322 | Date/Time Prepared: 5/30/2013 9:13 am
Title XVIII | Swing Beds - SNF | Cost

		Part A 1.00	Part B 2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	770,310	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 5 and 7, line 202 for Part B) (For CAH, see instructions)	263,100	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	631	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,033,410	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,033,410	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,033,410	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,503	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,026,907	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
17.00	Reimbursable bad debts (see instructions)	0	0	17.00
18.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (sum of lines 15 and 17, plus/minus line 16)	1,026,907	0	19.00
20.00	Interim payments	908,492	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus the sum of lines 20 and 21)	118,415	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet E-3 Part V | Date/Time Prepared: 5/30/2013 9:13 am

Title XVIII | Hospital | Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	5,516,655	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	5,516,655	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,571,822	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	5,571,822	19.00
20.00	Deductibles (exclude professional component)	563,888	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20)	5,007,934	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	5,007,934	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	84,039	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	84,039	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	34,128	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,091,973	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	5,091,973	30.00
31.00	Interim payments	4,607,117	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus the sum of lines 31, and 32)	484,856	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G | Date/Time Prepared: 5/30/2013 9:13 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,412,668	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	10,190,302	0	0	0	4.00
5.00	Other receivable	59,385	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,500,148	0	0	0	6.00
7.00	Inventory	709,824	0	0	0	7.00
8.00	Prepaid expenses	642,599	0	0	0	8.00
9.00	Other current assets	8,531,941	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	22,046,571	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	33,603,878	0	0	0	15.00
16.00	Accumulated depreciation	-20,120,903	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,482,975	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	1,002,503	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,002,503	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	36,532,049	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	595,597	0	0	0	37.00
38.00	Salaries, wages, and fees payable	939,226	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	450,795	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,577,715	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,563,333	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,185,063	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	1,185,063	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	4,748,396	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	31,783,653				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	31,783,653	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	36,532,049	0	0	0	60.00

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		30,614,665		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,142,857				2.00
3.00	Total (sum of line 1 and line 2)		31,757,522		0		3.00
4.00	Additions (credit adjustments) (specify)	26,131		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		26,131		0		10.00
11.00	Subtotal (line 3 plus line 10)		31,783,653		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		31,783,653		0		19.00

		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet G-2 Parts I & II | Date/Time Prepared: 5/30/2013 9:13 am

	Cost Center Description	Inpatient 1.00	Outpatient 2.00	Total 3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,365,928		3,365,928	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,365,928		3,365,928	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	972,102		972,102	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	972,102		972,102	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,338,030		4,338,030	17.00
18.00	Ancillary services	16,431,783	42,624,828	59,056,611	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,121,397	2,121,397	22.00
23.00	AMBULANCE SERVICES	0	2,273,176	2,273,176	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PRO FEES	218,839	4,984,108	5,202,947	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	20,988,652	52,003,509	72,992,161	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		33,734,986		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	NON-OPERATING EXPENSES	4,325,089			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		4,325,089		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		29,409,897		43.00

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	72,992,161	1.00
2.00	Less contractual allowances and discounts on patients' accounts	42,002,154	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,990,007	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,409,897	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,580,110	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	367,809	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	1,340,855	24.00
24.01	NON-OPERATING REVENUE	3,452,304	24.01
25.00	Total other income (sum of lines 6-24)	5,160,968	25.00
26.00	Total (line 5 plus line 25)	6,741,078	26.00
27.00	NON-OPERATING EXPENSE	5,598,221	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	5,598,221	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,142,857	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H

HHA CCN: 157177 | Date/Time Prepared: 5/30/2013 9:13 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	28,042	0	0	0	158,338	186,380	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	146,855	0	14,082	0	0	160,937	6.00
7.00	Physical Therapy	0	0	7,310	89,160	0	96,470	7.00
8.00	Occupational Therapy	0	0	5,332	39,324	0	44,656	8.00
9.00	Speech Pathology	0	0	0	4,020	0	4,020	9.00
10.00	Medical Social Services	2,889	0	184	0	0	3,073	10.00
11.00	Home Health Aide	49,233	0	7,055	0	0	56,288	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	66,475	0	3,079	1,727	0	71,281	23.00
24.00	Total (sum of lines 1-23)	293,494	0	37,042	134,231	158,338	623,105	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	157,747	344,127	-2,574	341,553	5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	0	160,937	0	160,937	6.00
7.00	Physical Therapy	0	96,470	0	96,470	7.00
8.00	Occupational Therapy	0	44,656	0	44,656	8.00
9.00	Speech Pathology	0	4,020	0	4,020	9.00
10.00	Medical Social Services	0	3,073	0	3,073	10.00
11.00	Home Health Aide	0	56,288	0	56,288	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	71,281	0	71,281	23.00
24.00	Total (sum of lines 1-23)	157,747	780,852	-2,574	778,278	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-1 Part I

HHA CCN: 157177 | Date/Time Prepared: 5/30/2013 9:13 am

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	341,553	0	0	0	0	341,553	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	160,937	0	0	0	0	160,937	6.00
7.00	Physical Therapy	96,470	0	0	0	0	96,470	7.00
8.00	Occupational Therapy	44,656	0	0	0	0	44,656	8.00
9.00	Speech Pathology	4,020	0	0	0	0	4,020	9.00
10.00	Medical Social Services	3,073	0	0	0	0	3,073	10.00
11.00	Home Health Aide	56,288	0	0	0	0	56,288	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	71,281	0	0	0	0	71,281	23.00
24.00	Total (sum of lines 1-23)	778,278	0	0	0	0	778,278	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	341,553		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	125,866	286,803	6.00
7.00	Physical Therapy	75,447	171,917	7.00
8.00	Occupational Therapy	34,924	79,580	8.00
9.00	Speech Pathology	3,144	7,164	9.00
10.00	Medical Social Services	2,403	5,476	10.00
11.00	Home Health Aide	44,022	100,310	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	55,747	127,028	23.00
24.00	Total (sum of lines 1-23)		778,278	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-1 Part II
HHA CCN: 157177 | Date/Time Prepared: 5/30/2013 9:13 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-341,553	436,725	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	160,937	6.00
7.00	Physical Therapy	0	0	0	0	0	96,470	7.00
8.00	Occupational Therapy	0	0	0	0	0	44,656	8.00
9.00	Speech Pathology	0	0	0	0	0	4,020	9.00
10.00	Medical Social Services	0	0	0	0	0	3,073	10.00
11.00	Home Health Aide	0	0	0	0	0	56,288	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	71,281	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-341,553	436,725	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		341,553	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.782078	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-2 Part I
HHA CCN: 157177 | Date/Time Prepared: 5/30/2013 9:13 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS: NEW BLDG & FIXT	CAPITAL RELATED COSTS: NEW MVBLE EQUIP	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	7,927	621	1,189	9,737	2,395	1.00
2.00	Skilled Nursing Care	286,803	0	0	0	286,803	70,550	2.00
3.00	Physical Therapy	171,917	0	0	0	171,917	42,289	3.00
4.00	Occupational Therapy	79,580	0	0	0	79,580	19,576	4.00
5.00	Speech Pathology	7,164	0	0	0	7,164	1,762	5.00
6.00	Medical Social Services	5,476	0	0	0	5,476	1,347	6.00
7.00	Home Health Aide	100,310	0	0	0	100,310	24,675	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	127,028	0	0	0	127,028	31,247	19.00
20.00	Total (sum of lines 1-19) (2)	778,278	7,927	621	1,189	788,015	193,841	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	17,177	0	5,026	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	17,177	0	5,026	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-2 Part I | Date/Time Prepared: 5/30/2013 9:13 am

HHA CCN: 157177 | Home Health Agency I | PPS

	Cost Center Description	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs	
		16.00	24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	0	34,335	0	34,335			1.00
2.00	Skilled Nursing Care	0	357,353	0	357,353	12,653	370,006	2.00
3.00	Physical Therapy	0	214,206	0	214,206	7,584	221,790	3.00
4.00	Occupational Therapy	0	99,156	0	99,156	3,511	102,667	4.00
5.00	Speech Pathology	0	8,926	0	8,926	316	9,242	5.00
6.00	Medical Social Services	0	6,823	0	6,823	242	7,065	6.00
7.00	Home Health Aide	0	124,985	0	124,985	4,425	129,410	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	158,275	0	158,275	5,604	163,879	19.00
20.00	Total (sum of lines 1-19) (2)	0	1,004,059	0	1,004,059	34,335	1,004,059	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.035407		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 151322 HHA CCN: 157177

Period: From 01/01/2012 To 12/31/2012

Worksheet H-2 Part II Date/Time Prepared: 5/30/2013 9:13 am

Home Health Agency I

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET) 1.00	NEW MVBLE EQUIP (SQUARE FEET) 2.00	EMPLOYEE BENEFITS (GROSS SALARIES) 4.00	Reconciliation 5A	ADMINISTRATIVE & GENERAL (ACCUM. COST) 5.00	OPERATION OF PLANT (SQUARE FEET) 7.00	
1.00	Administrative and General	588	588	293,494	0	9,737	588	1.00
2.00	Skilled Nursing Care	0	0	0	0	286,803	0	2.00
3.00	Physical Therapy	0	0	0	0	171,917	0	3.00
4.00	Occupational Therapy	0	0	0	0	79,580	0	4.00
5.00	Speech Pathology	0	0	0	0	7,164	0	5.00
6.00	Medical Social Services	0	0	0	0	5,476	0	6.00
7.00	Home Health Aide	0	0	0	0	100,310	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	127,028	0	19.00
20.00	Total (sum of lines 1-19)	588	588	293,494		788,015	588	20.00
21.00	Total cost to be allocated	7,927	621	1,189		193,841	17,177	21.00
22.00	Unit cost multiplier	13.481293	1.056122	0.004051		0.245986	29.212585	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 8.00	HOUSEKEEPING (SQUARE FEET) 9.00	DIETARY (MEALS SERVED) 10.00	CAFETERIA (FTE'S) 11.00	NURSING ADMINISTRATION (DIRECT NRSING HRS) 13.00	MEDICAL RECORDS & LIBRARY (TIME SPENT) 16.00	
1.00	Administrative and General	0	588	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	588	0	0	0	0	20.00
21.00	Total cost to be allocated	0	5,026	0	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	8.547619	0.000000	0.000000	0.000000	0.000000	22.00

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	370,006		370,006	2,372	155.99	1.00
2.00	Physical Therapy	3.00	221,790	0	221,790	1,406	157.75	2.00
3.00	Occupational Therapy	4.00	102,667	0	102,667	769	133.51	3.00
4.00	Speech Pathology	5.00	9,242	0	9,242	70	132.03	4.00
5.00	Medical Social Services	6.00	7,065		7,065	27	261.67	5.00
6.00	Home Health Aide	7.00	129,410		129,410	1,303	99.32	6.00
7.00	Total (sum of lines 1-6)		840,180	0	840,180	5,947		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A Program Visits	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		15999	721	548			8.00
9.00	Physical Therapy		15999	722	386			9.00
10.00	Occupational Therapy		15999	358	223			10.00
11.00	Speech Pathology		15999	9	39			11.00
12.00	Medical Social Services		15999	8	15			12.00
13.00	Home Health Aide		15999	182	182			13.00
14.00	Total (sum of lines 8-13)			2,000	1,393			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	87,128	0.000000	15.00
16.00	Cost of Drugs	9.00	0	182	182	759	0.239789	16.00

	Cost Center Description	Part A Cost of Services	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance			
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	721	548		112,469	85,483		1.00
2.00	Physical Therapy	722	386		113,896	60,892		2.00
3.00	Occupational Therapy	358	223		47,797	29,773		3.00
4.00	Speech Pathology	9	39		1,188	5,149		4.00
5.00	Medical Social Services	8	15		2,093	3,925		5.00
6.00	Home Health Aide	182	182		18,076	18,076		6.00
7.00	Total (sum of lines 1-6)	2,000	1,393		295,519	203,298		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-3 Part II
HHA CCN: 157177 | Date/Time Prepared: 5/30/2013 9:13 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.417024	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.270796	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.500630	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.111142	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.240044	759	182	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 151322 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-4 Part I-II

HHA CCN: 157177 | Date/Time Prepared: 5/30/2013 9:13 am

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	176	0	1.00
2.00	Total charges	0	759	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	759	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	583	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services 1.00	Part B Services 2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	176	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	298,057	198,431	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	3,030	4,199	13.00
14.00	Total PPS Reimbursement - PEP Episodes	733	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	301,820	202,806	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	301,820	202,806	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	301,820	202,806	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00

		Part A Services 1.00	Part B Services 2.00	
29.00	Total costs - current cost reporting period (line 26 plus line 27)	301,820	202,806	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	301,820	202,806	31.00
32.00	Interim payments (see instructions)	301,820	203,362	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 32 and 33)	0	-556	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 151322 | HHA CCN: 157177 | Period: From 01/01/2012 To 12/31/2012 | Worksheet H-5 | Date/Time Prepared: 5/30/2013 9:13 am

		Inpatient Part A		Home Health Agency I Part B	PPS	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		301,820		203,362	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		301,820		203,362	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		556	6.02
7.00	Total Medicare program liability (see instructions)		301,820		202,806	7.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 151322
HHA CCN: 157177

Period: From 01/01/2012 To 12/31/2012

Worksheet H-5

Date/Time Prepared: 5/30/2013 9:13 am

PPS

			Home Health Agency I Contractor Number	Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00